# Emergency Allergic Reaction and Anaphylaxis

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

**Circle, check, and complete all appropriate blanks.**
Date:_____ Time:_____
**If the patient appears to be experiencing anaphylactic shock (facial and airway swelling with shortness of breath, generalized flushing and itching, unstable dropping blood pressure, cyanosis, loss of consciousness, especially if there is a history of prior anaphylaxis to the same agent), provide 0.5 ml 1/1000 epinephrine subcutaneously or by any other parenteral (non-oral) route, provide oxygen by mask at maximum flow, initiate IV with any fluid at KVO, and activate EMS. Contact the HCP after activating EMS. If EMS takes more than 15 minutes to respond, may repeat epinephrine if symptoms return. Maintain careful time documentation. If this paragraph is not applicable, proceed below:**

**S: History:**
What caused the reaction? Specify if known: _____

Is there itching? Where?_____

Describe cough or other respiratory symptoms _____

Describe nausea, vomiting, abdominal cramps, diarrhea if present _____

Describe respiratory symptoms if any_____

Previous episode? When, what caused it, how severe?

Other medical diagnoses and medications? Recent changes in medication?

Exposure to new cosmetics, new over the counter medications,

**O: Physical Assessment:**
Vital signs (if EMS is activated, take every 5 minutes until they arrive, take temperature only once.)

| Temp | Initial | 5" | 10" | 15" | 20" |
|---|---|---|---|---|---|
| Time | | | | | |
| B/P | | | | | |
| Pulse | | | | | |
| Resp Rate | | | | | |
| O2 Sat | | | | | |

Inspect the skin for flushing, rash, hives (urticaria),_____

Is there edema on the face or in the oral cavity? _____

**A: Assessment**
- If patient is experiencing generalized symptoms without respiratory or cardiovascular changes, assess as "Allergic reaction systemic."
- If patient is experiencing immediate changes in respiratory or cardiovascular status associated with generalized allergic changes (as described in the first paragraph), assess "anaphylaxis."
- If the patient is experiencing only an elevated pulse and respiratory rate associate with anxiety, assess as "anxiety."

Assessment: _____

**P: Intervention:**
**For "anaphylaxis," as in the first paragraph.**
**If at anytime anaphylaxis is thought to be developing, proceed as in the top bold paragraph.**

For "allergic reaction – systemic":
- Contact HCP for direction
- Make sure the health record and problem list reflect the allergy
- Educate the patient to avoid the stimulus in the future.
- If the stimulus is a medication, encourage the patient to always inform health care providers and label the patient's chart as being allergic to this medication.

For anxiety
- Reassure patient.
- If this is not the first such visit, schedule patient to HCP for review.

Nurse's signature and date:

Reviewer's signature and date:

# Non-Emergent
# Allergic Reaction

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
**If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.**

Date:_____ Time:_____
**If the patient appears to be experiencing anaphylactic shock (facial and airway swelling with shortness of breath, generalized flushing and itching, unstable dropping blood pressure, cyanosis, loss of consciousness, especially if there is a history of prior anaphylaxis to the same agent), provide 0.5 ml 1/1000 epinephrine subcutaneously or by any other parenteral (non-oral) route, provide oxygen by mask at maximum flow, initiate IV with any fluid at KVO, and activate EMS. Contact the HCP after activating EMS. If EMS takes more than 15 minutes to respond, may repeat epinephrine if symptoms return. Maintain careful time documentation. If this paragraph is not applicable, proceed below:**

**S: Subjective:**
What symptoms does the patient have? _____
_____
_____
When did the symptoms begin, and how did they develop?___
_____
_____
Has the patient previously had a similar reaction? Describe: __
_____
_____
Does the patient have difficulty breathing?_____
Inquire specifically for symptoms listed in bold paragraph on anaphylaxis. _____
_____
_____
Does the patient know what caused the reaction? _____
_____
_____
Does the patient have any other active problems or serious medical conditions? _____
_____
_____
List current medications:_____
_____
_____

**O: Examination:**
T:_____ P:_____ R:_____ B/P: _____ WT:_____
Examine skin for erythema, hives, blisters, or other abnormality. Describe: _____
_____
_____
Listen to the neck and chest _____
_____
If an insect bite is involved, examine site carefully and identify retained insect parts if any _____

**A: Assessment:**
If there is a single lesion with or without retained insect parts with or without a central puncture, there is no sign of pus, and patient gives a history of an insect bite, assess "insect bite."
If there is a history of a food allergy and the patient has or may have been exposed, and there is a generalized rash (that may resemble previous rashes), assess "food allergy."
If there are blisters in small grouped areas, especially in linear streaks or where jewelry contacts the skin, assess "contact dermatitis."
If there are generalized hives (urticaria, welts) and there is no identified exposure to an allergen, assess "urticaria of unknown etiology."
If there are inflamed hair follicles or papules in a follicular distribution, with or without pustules, assess "alteration in skin integrity - possible folliculitis."
Assessment_____

**P: Interventions:**
Educate the patient regarding avoidance and protection.
For a simple insect bite
- Reassure the patient that no specific treatment is necessary.

For a food allergy
- Advise the patient to avoid the specific food
- Schedule patient to HCP for assessment of the need for a therapeutic diet

For contact dermatitis
- Advise thorough washing of skin and clothes to avoid additional areas of involvement
- (If poison ivy is suspected, show patient a picture or drawing of poison ivy)
- Advise that the rash will disappear over a 7 to 10 day period
- Advise regarding avoidance of additional contact with the offending agent
- Advise that scratching may produce an infection and delay healing
- Advise that blisters should be left intact
- If the patient is in severe discomfort, contact HCP and anticipate orders for hydrocortisone cream 1%.
- Advise patient to return if the rash worsens or if draining infection develops
- If rash is extensive or accompanied by more than minimal weeping or erythema, contact HCP for direction.

For urticaria (hives) of uncertain etiology
- If extensive, contact HCP and anticipate orders for oral or intramuscular diphenhydramine and provide appointment with HCP prior to expiration of the diphenhydramine
- If not extensive, provide routine appointment with HCP

For folliculitis without fever and without drainage
- Schedule patient to see HCP as per routine.

For folliculitis with fever or with drainage
- Contact HCP for direction

Comments: _____
_____
Nurse's signature and date:
_____
Reviewer's signature and date:
_____



*D2427DP23004PNXN*

# Altered Mental Status

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |



## I. REFERENCES: NCCHC J-E-11 NCCHC P-E-11

## II. BACKGROUND:

Altered mental status is a potentially life threatening condition with behavior ranging from subjective difficulty thinking clearly to abnormal thought content . Unfortunately, there are numerous causes of this state. Some of these causes are straightforward while others are more complex. Knowledge of these underlying disease states is crucial when evaluating a patient with altered mental status.

The potential causes for alteration in behavior may reflect systemic illness, organ system dysfunction, drug intoxication or withdrawal, mental illness, or neurologic disease. These causes vary in severity and frequency. It is prudent to address the life threatening causes first; these include hypoxia, hypoglycemia, hyperglycemia, systemic infection, and recent head trauma.

Most of these disorders can be ruled out at the bedside with some simple diagnostic test and a brief history and physical exam. Disruption in blood glucose is readily assessed by obtaining a finger-stick glucose. Hypoxia can be ruled out with an oxygen saturation reading. Fever is often a sound clinical indicator for systemic infection, but patients, often the elderly, can exhibit hypothermia in the presence of a significant infection. Trauma can usually be determined by a brief history and directed physical exam, but in some instances occult injuries or slowly developing intracranial hemorrhage can be present; frequent reevaluation of patients suspected of having such injuries is crucial as early intervention can be life-saving.

Medication intoxication and substance abuse or withdrawals are common causes of altered behavior. Obtaining a good history of drug use or substance abuse is essential. This history should include type of drug (prescription, illicit, or over the counter) or substance, last dose, and amount taken.

Other common causes of altered mental status include thyroid dysfunction, heart disease, liver disease, kidney disease, dementia, seizure disorder, lung disease, and mental illness. Once life threatening causes of altered mental status have been ruled out, it is often necessary to attempt to determine if the cause of the condition is due to medical or psychiatric causes. There are numerous bedside tests to assess cognition. The Six-Item Screen of Confusion (SIS) is a brief and easy to administer tool to evaluate cognition. It is clinically tested and has been found to be 94% sensitive and 86% specific in identifying cognitive impairment when compared to the gold standard of the lengthier Mini Mental Status Exam (MMSE). A score below 5 on the SIS indicates a non-psychiatric or medication-related cognitive impairment.

While patients with altered mental status can be complex, the challenge can be simplified using history and physical assessment, simple bedside diagnostic tests, and screens of cognition such as the SIS.

# Altered Mental Status

(This is a two page flow sheet)

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |



## III SUBJECTIVE:

- Inquire regarding the patient's history of disease states potentially causing altered mental status.
- Ask about medication use including prescription, illicit, and over-the-counter.
- Ask about substance abuse/withdrawal.
- Inquire about current symptoms.
- Assess overall level of consciousness.

## IV OBJECTIVE

- Obtain finger-stick blood glucose, oxygen saturation, temperature, and orthostatic vital signs.
- Perform the Six-Item Screen of Confusion (SIS).
- Obtain a dip-stick urinalysis.
- Perform a problem focused physical exam noting any jaundice, pedal edema, wheezing, signs of acute infection or recent trauma, or unilateral weakness.

## V ASSESSMENT

Assess, "Alteration in mental status"

## VI PLAN

- Initiate appropriate nursing interventions for any emergent findings.
- Call HCP on-call for further instructions.

## VII AUTHORITY

Dean Rie _____ ledical Officer CCS _____ 8-11-09 Date

Site Medical Director _____ Date _____

# Anal Discomfort

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time:_____

**S: Subjective:**

Inquire regarding the patient's symptoms. What bothers the patient, when did they first present, how often are they present?

_____
_____

Inquire if the patient has ever been diagnosed with hemorrhoids._____
Inquire regarding trauma._____
_____
Ask specifically regarding bleeding._____
_____
_____
Inquire regarding constipation._____
_____
_____
Inquire regarding melena (dark tarry stools). _____
_____
_____
Inquire regarding the presence of other serious medical disorders.

_____
_____

**O: Examination:**

**Notes: If there is a history of melena or of copious bleeding, obtain pulse and blood pressure (sitting and standing), as well as respiration rate. Look for orthostatic changes. A chaperone must be present for anal examination (preferably same gender, but either gender is acceptable).**
Inspect the anus. _____
_____
_____
_____
Palpate for masses (digital rectal examination may be performed if the nurse has been trained in its performance).__
_____
_____

**A: Assessment:**

If dilated veins are present in anal verge, assess "hemorrhoids, external."
If the skin directly around the anus exhibits a tear (with or without bleeding), assess "anal fissure."
If there is a firm, hard bluish vein associated with severe pain, assess "hemorrhoid, rule out thrombosis."
If nothing is identified, assess "alteration in comfort, anus, unknown etiology."
If there is evidence of trauma, assess "anal trauma."
Assessment _____

**P: Interventions:**

For "hemorrhoids, external,"
- Advise patient of findings.
- Advise patient to eat available fruits and vegetables (cooked or raw), to eat whole grain foods as available, and to increase water intake to six-eight glasses daily.
- Advise patient to wash the hemorrhoid when showering.
- Advise patient that the hemorrhoid may occasionally itch or bleed slightly, and to return if severe pain or copious bleeding develops.

For "anal fissure,"
- Provide same advice as above regarding foods and water.
- Advise the patient that anal fissures can be very painful and may bleed slightly.
- Schedule the patient to be seen by a HCP within the next two weeks (follow up and examination to rule out any mass lesion).

For "hemorrhoid, rule out thrombosis,"
- Advise the patient as above for external hemorrhoids.
- Refer patient for HCP evaluation within 2 business days.

For "alteration in comfort, anus, unknown etiology,"
- Refer patient to HCP evaluation within 7 days.

For "anal trauma,"
- Call HCP for direction.

Comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____



*D2428DP35197PNXN*

# Anxiety

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient complains of: _____

Keeping interview open ended, including information regarding sleep habits, weight changes, headaches, and other nonspecific symptoms. _____

Inquire whether the patient is experiencing auditory or visual hallucinations (hearing or seeing things that others do not), has any particular fears, or has not slept in more than one day. ___

Inquire regarding suicidal ideation or attempts: _____

Inquire regarding any recent changes in medications, current prescribed medications, or other serious medical problems: __

**O: Examination:**

T: _____ P:_____ R:_____B/P:_____ WT:_____
Describe skin _____

Describe patient's affect: _____

Is patient oriented x3? _____

**A: Assessment:**

- If vital signs are abnormal other than mild elevations in pulse and blood pressure, this protocol is not applicable. Consider another protocol or refer accordingly.
- If patient admits/alleges hallucinations or no sleep in more than one day, this protocol is not applicable. Refer to mental health professional. If there is a history of suicidal gestures or recent ideation, make referral same day or immediate.
- If the patient exhibits acute fear accompanied by severe tachypnea (rapid rate of breathing), assess "panic attack with hyperventilation"
- If the patient exhibits acutely disabling anxiety without tachypnea (rapid rate of breathing), assess "panic attack, first episode" or "panic attack, recurrent."
- If the patient exhibits anxiety and an obvious cause has been reported, assess "anxiety, normal response to life episode."
- If the patient exhibits anxiety and is newly resident at the facility (less than six months), assess "anxiety, normal response to environment."
- If the patient exhibits persistent disabling anxiety (symptoms more than just sleep disturbance and occasional concern), assess "persistent anxiety."
- If the patient reports suicidal ideation or symptoms consistent with a major mental illness, do not assess "anxiety."

Assessment:_____

**P: Interventions:**

For "panic attack with hyperventilation," "panic attack, first episode," or "panic attack, recurrent"

- Provide a paper bag for two minutes of rebreathing.
- If this terminates the panic attack and this was an isolated event, reassure the patient.
- If the panic attack does not terminate or is recurrent, contact a mental health provider for advice.

For "anxiety, normal response to environment"

- Reassure patient and do not refer.

For "persistent anxiety" or other mental disorder,

- Refer patient to mental health provider, immediately if the anxiety is disabling, psychosis is present, or suicidal intent is suspected.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

# Arthritis

| Patient Name | Patient Number | Booking Number | Date of Birth | Today's Date |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date:_____ Time:_____

**S: Subjective:**
Determine whether the patient has ever been treated for joint problems. If so, please detail type of problem (rheumatoid arthritis, osteoarthritis, gout, etc) and medications used. _____

Have the patient identify which joints are involved. ____

Determine how long the joints have hurt and the severity of the pain. _____

Inquire whether the discomfort stops the patient from carrying out any activities of daily living (specific to patient's current environment) or participating in recreational activities. _____

**O: Examination:**
T: _____ P:_____ R:_____
Obtain temperature. (If temperature is abnormal, obtain pulse, blood pressure, and respiration rate.) _____

Inspect all involved joints. Note discoloration. _____

Palpate involved joints. Note heat or local tenderness. Note any joint swelling. _____

Gently move the involved joints through their ranges of motion and note the response (passive range of motion). Observe the patient moving his own joints and note the response (active range of motion). _____

Observe the patient's movements. (Gait, dressing or undressing, climbing onto an examination table, etc.) __

**A: Assessment:**
- If the patient has one or more joints that are red and tender and a history of gout or pseudogout, assess as "gout or pseudogout."
- If the patient has one or more joints that are red and tender and no history of gout or pseudogout, assess as "inflamed joint, rule out infection."
- If the patient has only minimal discomfort, no joint swelling, and no deterioration of ADLs, assess as "joint discomfort, minimal."
- If the patient has one or more joints involved and none of the above three choices apply, assess as "possible arthritis."

Assessment
_____

**P: Interventions:**
For "gout or pseudogout" or "inflamed joint, rule out infection"
- Contact HCP for direction.

For "joint discomfort, minimal"
- Advise patient to avoid trauma to involved joints including jogging, weight lifting, games such as basketball, and so on.
- Advise patient that no serious medical condition is present.

For "possible arthritis"
- Refer patient to HCP as per routine.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____



*D2431DP35709PNXN*

# Asthma Exacerbation

| Patient Name | Patient Number | Booking Number | Date of Birth | Today's Date |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.
Date: _____ Time: _____

**S: Subjective:**
Modify history-taking according to patient's status.
When did exacerbation start? _____
_____
_____
What has the patient done to manage it? _____
_____
_____
_____
When was the last exacerbation, and what did it take to treat it?_____
_____
_____
What medication does the patient usually use, what medication was used prior to and since the exacerbation started? _____
_____
_____
_____

**O: Examination:**
T: _____ P:_____ R:_____Oxy Sat:_____
Peak expiratory flow rate (PEFR) (if patient can cooperate):
_____
Look at the nail beds and skin around the mouth for cyanosis (a bluish hue): _____
_____
_____
_____
Observe the patient's position of comfort. _____
_____
_____
Observe the chest wall for retractions _____
_____
_____
Listen to the chest and neck _____
_____
_____
_____

**A: Assessment:**
- All vital signs are normal, no wheezing is heard although there may be noises in the neck, oxygen sat is above 91% - "no asthma exacerbation."
- Pulse is below 110 bpm, rr is below 25, wheezing is present especially end-inspiration, patient is uncomfortable but can move around and lie down, oxygen sat is above 91%, and PEFR can be obtained and is 80% of expected or better – "mild asthma exacerbation."
- Pulse is between 110 and 120, rr is still below 25, exhibits agitation but not somnolence or confusion, wheezing is widespread and loud, both inspiratory and expiratory, oxygen sat is 91% or better, and PEFR can be obtained and is between 50 and 80% - "moderate asthma exacerbation."
- Pulse is above 120, rr is above 25, patient insists on sitting upright and leaning forward, patient is anxious and may exhibit somnolence or confusion, oxygen sat is below 90, cyanosis may be present, and PEFR, if obtainable, is below 50% of expected – "severe asthma exacerbation."

**Beware the "silent chest." An asthma patient who stops wheezing but who remains symptomatic and whose lungs are silent is not moving air. Respiratory collapse is imminent!**
Assessment _____

**P: Interventions:**

For "severe exacerbation" (these are emergency interventions)
- Maintain airway and be ready to provide CPR if necessary.
- Administer oxygen by mask at 10 lpm.
- Administer nebulizer treatment with Albuterol solution (1 ml of 5 mg/ml in 4 ml NS)
- If no nebulizer treatment can be administered, administer epinephrine 0.3 mg (0.3 ml of 1:1000 solution) SC.
- If respiratory arrest appears imminent, provide both Albuterol and epinephrine treatments.
- Contact HCP (if a second person is available, this can be accomplished simultaneously with the above live-saving interventions.)
- Monitor for improvement subjectively (patient feels better) and objectively (vital signs and oxygen saturation improve)
- Repeat Albuterol and epinephrine treatments in 20 minutes and update vital signs and PEFR unless HCP directs otherwise.
- If HCP has not responded and given direction and an additional 20 minutes goes by, repeat treatments (every 20 minutes) and activate the EMS system.

For "mild or moderate exacerbation"
- Administer nebulizer treatment with Albuterol solution (1 ml of 5 mg/ml in 4 ml NS) or with patient's metered dose inhaler depending upon availability, existing orders, and patient's ability to use the inhaler. (Increasing severity of exacerbation should increase the likelihood of nebulizer use.)
- If no nebulizer treatment can be administered, administer epinephrine 0.3 mg SC (0.3 ml of 1:1000 solution).
- Contact the HCP for additional direction.
- Repeat albuterol treatment every 20 minutes and record updated vital signs and PEFR until the HCP provides direction.

For "no exacerbation"
- Reassure patient.

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

# Asthma Inhalers at Intake

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.

Date: _____ Time: _____

**S: Subjective:**

List medications that the patient alleges. _____
_____
_____
_____
_____
How long has the patient had asthma? _____
_____
_____
When was the last exacerbation, and how severe was it? ____
_____
_____
_____
Does the patient have an inhaler or other medication? Describe, and copy the name of the pharmacy that dispensed it. If time permits, call the pharmacy and verify. _____
_____
_____
_____
_____
When was medication used during the last 48 hours? What medication and when? _____
_____
_____
_____
_____
_____
_____

**O: Examination:**

P:_____ R:_____B/P:_____ Oxygen sat:_____
Unless patient is experiencing an exacerbation, have patient sit at least 20 minutes after the last cigarette and then listen to lungs for wheezing._____

**A: Assessment:**

- If patient is uncomfortable and currently wheezing, assess as "current asthma exacerbation" and exit this protocol.
- For other allegations of asthma, assess as "alteration in respiratory function, asthma (or chronic obstructive pulmonary disease in accordance with the history)."

Assessment _____

**P: Interventions:**

- If patient has not been using medication for the past 48 hours and has no current symptoms, schedule patient to be seen within 7 days.
- If patient has been using medication and has no current symptoms, contact HCP for direction.
- For other circumstance, contact HCP for direction.

Comments: _____
_____
_____
_____
_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

# Back Pain

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Recent trauma or surgery? _____

Previous episodes? _____

Back surgery? _____

Recent physical activity, especially unaccustomed? _____

Describe pain-location, onset, radiation, duration, intensity ___

Exacerbating and alleviating factors _____

Loss of bladder or bowel control _____

Numbness or pain shooting into legs or feet? _____

Loss of motor function _____

**O: Examination:**

Observe the patient walking into the room and changing out of his clothing. _____

T: _____ P:_____ R:_____B/P:_____ WT:_____

If observed gait does not match patient claims, contact security staff and obtain information regarding recent performance. ___

**A: Assessment:**

If findings are essentially normal other than subjective complaints and minimal restrictions in range of motion or other observed activities, assess "alteration in comfort – back pain, nonspecific."

If any serious abnormal findings are noted (as described above) i.e. loss of bowel or bladder control, loss or alteration in motor function numbness, etc, assess "alteration in comfort – back pain, with serious abnormal findings"

If the assessment does not clearly fall into either of the above categories or if the patient has a history of back surgery and is presenting with newly recurrent or new symptoms, assess "alteration in comfort – back pain of uncertain etiology."

**P: Interventions:**

For "alteration in comfort – back pain, nonspecific"

- Advise reduction in activity level but do not advise bed rest. The patient should remain active as limited by pain.
- Patient may return to clinic PRN, but if this is a return visit, schedule to HCP as per routine.
- Provide a temporary activity restriction as necessary.
- If the patient appears to have severe pain, provide acetaminophen 975 PO BID for 2 days. (Anti-inflammatory medication has no advantage over acetaminophen in relieving pain.) If the patient has a documented allergy to acetaminophen, you may provide ibuprofen 200mg PO TID for 2 days instead (unless otherwise contraindicated).
- Provide general education regarding posture, body mechanics, and weight. Be aware that inmates prefer bottom bunks, and avoid any suggestion of a permanent bottom bunk assignment in response to a self-limited problem.

For "alteration in comfort – back pain, with serious abnormal findings" or "alteration in comfort – back pain of uncertain etiology"

- Place patient at rest and contact the HCP for direction.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:



*D2436DP2201PNXN*

# Breast Mass - Female

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.

Date: _____ Time: _____
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

**S: Subjective:**

How long has the mass been present? _____

Has the patient previously had breast cancer? _____

Does the patient have a nipple discharge? Describe. _____

When was the last menstrual period? _____

**O: Examination:**

T: _____
Inspect both breasts, noting especially any masses, redness, or other changes_____

Palpate both breasts looking for masses and feeling for heat.

**A: Assessment:**

- If no mass is palpated, assess as "possible breast mass by history."
- If signs of infection are present assess as "breast mass – possible infection."
- If a solitary mass is palpated, assess as "breast mass – solitary."
- If multiple masses are palpated, assess as "breast masses – multiple."
- If breasts are too glandular for a decision, assess as "possible breast mass by history."

Assessment: _____

**P: Interventions:**

**For patients who are still having regular periods:**

For "possible breast mass by history" and other masses that have not been present for a full menstrual cycle

- Instruct patient that breast masses sometimes disappear after a full single menstrual cycle.
- Schedule patient back for an examination after the next menstruation.
- If this is the return visit, schedule patient to see the HCP as per routine.

For "breast mass – possible infection"

- Contact HCP for direction.

For "breast mass – solitary or multiple" that has persisted for more than a full cycle

- Schedule patient to see the HCP as per routine.

**For patients who are no longer having periods:**
For "breast mass – possible infection"

- Contact HCP for direction.

For all other assessments

- Schedule to see HCP as per routine.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:



*D2437DP19653PNXN*

# Breast Mass - Male

| Patient Name | Inmate Number | Booking Number | Date of Birth | Today's Date |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

How long has the mass been present? _____

Does the mass hurt? Describe _____

Is there a nipple discharge? Describe _____

Are both sides involved? _____

List medications (OTC and prescription) _____

List drugs of abuse, especially alcohol, marijuana, and anabolic (body building) steroids _____

**O: Examination:**

T: _____
Inspect both breasts, noting especially any masses, redness, or other changes _____

Palpate both breasts looking for masses and feeling for heat.

Note the quantity and characteristics of any nipple discharge

**A: Assessment:**

- If no enlarged glandular tissue is noted, assess "subjective breast enlargement without pathology."
- If enlarged breasts without glandular tissue is noted, assess "breast enlargement associated with obesity."
- If bilateral excess glandular tissue is noted, assess "bilateral gynecomastia."
- If unilateral excess glandular tissue is noted, assess "unilateral gynecomastia."
- If a nipple discharge is noted, assess "breast mass with discharge."

Assessment: _____

**P: Interventions:**

For "subjective breast enlargement without pathology"
- Reassure patient.
- If this is the third time patient has complained about this problem, refer to HCP as per routine.

For "breast enlargement associated with obesity"
- Reassure patient.
- Do not refer to the HCP.

For "bilateral gynecomastia"
- Reassure patient that bilateral gynecomastia is not pathological.
- If a likely cause (typically alcohol, marijuana, or anabolic steroid use) is identified during the history, inform patient regarding association.
- If this is the third time patient has complained about this problem, refer to HCP as per routine.

For "unilateral gynecomastia" or "breast mass with discharge," refer patient to HCP as per routine.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:



* D 2 4 3 8 D P 2 5 2 0 2 P N X N *

# Burns

**(this is a two page flow sheet)**

CCS CORRECT CARE SOLUTIONS



| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.

Date:_____ Time:_____

**S: Subjective:**

If the situation is urgent, defer history and intervene.

- Safely remove the patient from the source of the burn.
- Move the patient far enough away to avoid further smoke inhalation.
- Immerse scalds or grease burns in cold water.
- If clothes are on fire, roll the patient on the ground until the flames are extinguished or douse the patient with water, or wrap the patient in a blanket to prevent air from feeding the fire. Cut away clothing unless it is adherent to flesh.
- If chemical burns were suffered, wash away chemicals with large amounts of water. Cut away clothing unless it is adherent to flesh.
- In case of electrical burns, DO NOT TOUCH THE PATIENT UNTIL INSURING THAT THE ELECTRICITY HAS BEEN SHUT OFF.

If the circumstances permit, obtain the following history:

Time of injury_____

Place where injury occurred _____

_____

Burn mechanism _____

_____

Body area(s) involved _____

_____

_____

_____

_____

_____

Reported exposure to smoke _____

Additional injuries reported _____

_____

_____

_____

_____

_____

Prior history of serious illnesses _____

_____

_____

_____

_____

**O: Examination:**

P:_____ R:_____B/P:_____ Oxygen Sat ____

**Refer to protocol background section as necessary.**

- Assess the patient's Airway, Breathing, and Circulation
- Assess vitals signs (do not apply a blood pressure cuff to a second or third degree burn)
- Look for signs of smoke inhalation (singed face, smoke-stained nares or mouth, cough productive of sooty phlegm, etc)
- Estimate burn size by degree of burn (rule of nines-see page 2 of this pathway)
- Evaluate for critical burns (circumferential, perineum, facial, etc)
- Screen for other injuries

**A: Assessment:**

Assess burn severity by category and description:

Major burn (any one of these)

- Respiratory embarrassment
- Third degree on more than 10% of the body
- Second degree on more than 25% of the body
- Third degree to hand, foot, face, or genitalia
- Circumferential second or third degree burn
- High voltage or lightening burn

Moderate burn (two or more generally means major burn should be assessed)

- Third degree on 2-10% of the body
- Second degree on 15-25% of the body
- Second degree to hand, food, face, or genitalia
- Otherwise minor burn plus smoke exposure

Minor burn (two or more generally means moderate burn should be assessed)

- Third degree on less than 2% of the body
- Second degree on less than less than 15% of the body
- First degree burns of any extent

Assessment: _____

_____

_____

_____

_____

_____

# Burns

**(this is a two page flow sheet)**



| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

**P: Interventions:**

Treat any life threatening condition (ABCs of trauma)

For major burns (**this is emergency treatment**)

- Maintain airway
- Provide oxygen 8 lpm by mask
- Initiate IV fluids 0.9 NS at 200 ml/hour; obtain second IV line if possible
- Activate EMS and notify HCP as time allows.
- Repeat vital signs frequently
- Cover with wet sterile sheet if available. If EMS is slow to get to patient, cover wet sheet with blanket to help prevent hypothermia

For moderate burns

- If smoke exposure or upper body burns, provide oxygen 8 lpm by mask
- Initiate IV fluids 0.9% NS at KVO
- Notify the HCP

For minor burns

- If there second or third degree burns are present, notify the HCP
- If chemicals or contamination is present, gently wash the area with mild soap and water
- Leave blisters intact
- If patient has significant discomfort, offer aspirin 650 mg QID for two days (very effective in treating inflammation from first degree burns). If aspirin is contraindicated, offer acetaminophen 975 mg PO BID for two days
- Initiate daily wound care until healed; refer to HCP if burn worsens or does not show improvement within 3 days of routine wound care.
- Educate patient regarding general care and future avoidance

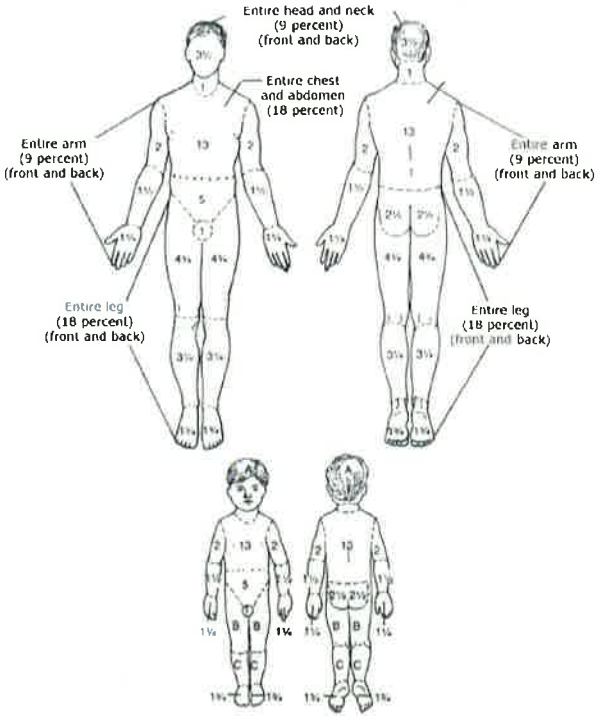
Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____




**Percentage based on age**

| | Birth- 1 yr | 1-4 yr | 5-9 yr | 10-14 yr | 15 yr | Adult |
|---|---|---|---|---|---|---|
| **A. Head** | 19 | 17 | 13 | 11 | 9 | 7 |
| **B. Thigh** | 5.5 | 6.5 | 8 | 8.5 | 9 | 9.5 |
| **C. Leg** | 5 | 5 | 5.5 | 6 | 6.5 | 7 |



* D 2 4 3 9 D P 6 2 0 2 5 P N X N *

# Chest Pain

**(this is a two page pathway)**

CCS CORRECT CARE SOLUTIONS



| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

**Perform an initial cursory assessment because acute myocardial infarction can evolve very rapidly into shock and abnormal heart rhythms can develop in a split second. The initial cursory assessments should include vital signs, oxygen saturation if there is any question of cardiovascular function, level of consciousness, and a risk factor history. If the patient is unstable, interventions such as oxygen by mask, sublingual nitroglycerin, intravenous access, and aspirin should be provided and the HCP contacted for further direction.**

If the above interventions are not necessary, proceed with this pathway.

Ask the patient to describe the pain. Encourage the patient to describe onset, relieving and worsening factors, location, nature, associated symptoms, and radiation _____

Rate the pain on a scale of 1-10, with 10 being the worst ____

Inquire about difficulty breathing and especially whether breathing causes or exacerbates the pain _____

Has the patient coughed up any blood, and how much? _____

Is the pain associated with food or eating? _____

List serious medical conditions _____

Review with patient standard cardiac risk factors (presence of diabetes, smoking history, older age, obesity, sedentary life style, previous heart disease, family history of heart disease, history of high cholesterol) _____

**O: Examination:**
P: _____ R: _____ BP: _____ Ox Sat:_____

Inspect the chest wall for any abnormal movements. _____

Inspect the nail beds, oral cavity, and skin around the mouth for cyanosis(a bluish hue)._____

Inspect for diaphoresis. Does the skin feel wet, cool, or clammy? _____

Listen to the heartbeat for irregularities in rhythm _____

Determine if the patient is alert, obtunded, or somnolent.
Inspect and palpate the lower extremities for edema, checking both left and right. _____

Listen to the chest for obviously abnormal sounds. _____

Palpate the chest for point tenderness, trying to reproduce the pain. _____

If cardiac disease has not been ruled out, obtain an EKG.
Results: _____

**A: Assessment:**

Assess one of the following:

- Alteration in circulation – possible heart attack
- Alteration in circulation – possible ischemia
- Alteration in comfort – dyspepsia
- Alteration in comfort – musculoskeletal pain
- Alteration in comfort – chest pain

If shock is impending or present (presentation consistent with heart attack and blood pressure below 90 systolic with or without alteration in consciousness), assess

- alteration in circulation – (impending) shock

Assessment _____

# Chest Pain

**(this is a two page pathway)**

CCS CORRECT CARE SOLUTIONS



| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

**P: Interventions:**

**Note: Intravenous medications and sublingual nitroglycerin included below are emergency interventions.**

For "alteration in circulation – (impending) shock"

- Administer oxygen by mask at 100% (at least 8 lpm)
- Place patient in semireclining position.
- Provide aspirin 325 mg po once, unless patient is known to be anticoagulated or is allergic to aspirin.
- Initiate IV with D5 if available; otherwise use what is available at "KVO" rate.
- (Nitroglycerin is not part of this treatment because of the already shocky blood pressure.)
- Apply cardiac monitor if available
- Obtain 12 lead EKG if available.
- Be alert for cardiopulmonary arrest; do not leave patient unattended unless that is briefly necessary to call for assistance. Repeat vital signs every 5 minutes.
- Activate EMS and contact HCP as time permits.

For "alteration in circulation – possible heart attack"

- Provide Nitroglycerin 0.4 mg SL every 5 minutes and repeat up to a total of three doses. (Check blood pressure before each dose and do not administer if diastolic blood pressure is below 60.)
- Provide aspirin 325 mg PO once unless patient is know to be allergic to aspirin.
- Be alert for patient deterioration and repeat vital signs approximately once every 5 minutes. Do not leave patient unattended except for brief periods.
- Contact HCP for direction.

For "alteration in circulation – possible ischemia"

- If oxygen saturation is below 95% administer oxygen by mask at 100% (at least 8 lpm).
- Place patient in semireclining position.
- Provide Nitroglycerin 0.4 mg SL every 5 minutes and repeat up to a total of three doses. (Check blood pressure before each dose and do not administer if diastolic blood pressure is below 60.)
- Be alert for patient deterioration and repeat vital signs approximately once every 5 minutes until chest pain is past or until given other direction. Do not leave patient unattended except for brief periods.
- Contact HCP for direction.

For "alteration in comfort – dyspepsia"

- Provide 60 cc of liquid antacid PO (or equivalent dose of tablet antacid if liquid is not available). If patient known to be in renal failure, contact HCP prior to administering.
- If pain is relieved, patient may return to unit and patient should be scheduled for chart review by the HCP at the next available clinic to determine appropriate plan of care and follow-up.
- If pain is not relieved, contact HCP for direction.

For "alteration in comfort – musculoskeletal pain"

- Advise patient regarding assessment
- Advise reduction in activity as required by pain
- If pain is severe, provide acetaminophen 975 PO BID for two days. If patient is known to be allergic to acetaminophen, then you may provide ibuprofen 200mg PO TID for two days instead (unless otherwise contraindicated).
- Advise patient to return if not better in two days.
- If this is the return, schedule to HCP as per routine.

Alteration in comfort – chest pain, nonspecific

- If pain is severe, contact HCP for direction.
- If pain is not severe, schedule to HCP as per routine.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

# Common Skin Problems - Acne

| Patient Name | Inmate Number | Booking Number | Date of Birth | Today's Date |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient complains of acne or pimples. Inquire:
What areas are involved? _____

What do you do to take care of your skin? _____

What did you do before you came to the facility? _____

Do you have any associated pain? _____

**O: Examination:**

Inspect the involved areas and describe _____

Palpate for deep cysts (as indicated by the patient) _____

**A: Assessment:**

Grade 1 acne if there are whiteheads, blackheads, and papules (pimples) without significant inflammation.
Grade 2 acne if there are also pustules, nodules, cysts, and inflammation.
Grade 3 acne if there also deep nodules down well into the dermis and the condition is painful.
Grade 4 acne if there are in addition deep cysts in association with scarring.
Assess _____

**P: Interventions:**

For Grade 1 acne
- Inform patient that the problem is cosmetic
- Provide patient with advice about keeping affected areas clean and using antibacterial soap issued by the facility if it is issued.

For Grade 2 acne
- Advise patient that the condition is primarily cosmetic.
- If the patient has a large number of pustules, refer to HCP for chart review for possible short course of antibiotics.

For Grade 3 or 4 acne
- Refer to HCP as per routine.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

# Common Skin Problems - Blisters

| Patient Name | Inmate Number | Booking Number | Date of Birth | Today's Date |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient complains of one or more blisters. Inquire
Where is/are the blister(s)? _____
_____
_____
_____
_____
_____
How did the blister develop (if the patient knows) _____
_____
_____
_____
Do the blisters hurt? _____
_____
_____
_____
If the blisters were formed by a burn, exit this pathway and use the pathway on burns.
If itching is a prominent symptom, exit this pathway and use the pathway on itching.

**O: Examination:**

T: _____ P:_____ R:_____
Inspect the affected areas and describe. Include size, location, color of fluid, presence of pus or drainage, and appearance of surrounding and underlying skin. _____
_____
_____
_____
_____
_____

**A: Assessment:**

If there are blisters associated with trauma by friction, assess as "alteration in skin integrity – friction blisters."
If there are painful blisters in groups on 1 side of the body (not crossing the midline), assess as "alteration in skin integrity – probable herpes zoster." A history of zoster supports the assessment.
If there are small numbers of tender blisters that have occurred before in the same place, and the blisters are on the genitals or the lips, assess "alteration in skin integrity – probable herpes simplex."
If the blisters do not fit any of these patterns, assess "blisters of unknown type."
Assessment _____

**P: Interventions:**

For "alteration in skin integrity – friction blisters"
Advise patient to avoid the activity that caused it.

- If the problem occurred on assignment, provide assistance in obtaining protective garment or equipment.
- If the problem developed from ill-fitting shoes, advise patient that he should consult with the appropriate clothing officer or office; health services does not address routine provision of properly fitting shoes or other garments.
- If the blister is infected, refer to HCP for routine evaluation per routine.

For "alteration in skin integrity – probable herpes zoster"

- If extensive areas are involved or patient is immuno-suppressed, refer to HCP per routine.
- If this rash is present on the face, contact HCP immediately for instructions.

For "alteration in skin integrity – probable herpes simplex"

- If this is the first occurrence, refer to HCP for evaluation per routine.
    - If this is a routine recurrence and reoccurrences occur monthly or more frequently, refer to HCP for evaluation per routine.
    - If this is a routine recurrence and they occur less often than monthly, reassure patient.
- Advise patient that the virus lives in the nerves and that recurrences are to be expected.
- If extensive areas are involved or patient is immunosuppressed, refer to HCP per routine.

For "blisters of unknown type"

- Refer to HCP for evaluation per routine.

Comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

# Common Skin Problems – Itching

**(this is a three page pathway)**

CCS CORRECT CARE SOLUTIONS



| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient complains of itching. Patient may volunteer that the skin looks "ashy" (African-American) or is dry. Inquire:
What problem is the patient complaining about? _____

When was it first noted? _____

Did it start suddenly or gradually? _____

Where is the problem? _____

Does the patient report any sores or lesions? _____

Does the patient scratch? Any particular time of day? _____

What makes the itching worse? What makes it better? _____

How often, for how long, and with what kind of soap does the patient shower or wash his face? Does the patient apply any lotion or other cosmetics to the involved areas? _____

Any other medical problems? _____

**O: Examination:**

T: _____
Inspect all areas that the patient reports itch. Describe, noting the type and distribution of lesions. _____

**A: Assessment:**

- If itching skin is "ashy" (or dry) and exhibits no significant lesions other than excoriations, or thickening with increased pigmentation where the patient has been scratching for a long time, and especially if the patient gives a history of prolonged washing (common in correctional settings), assess "Xerosis secondary to personal hygiene."
- If itching is located on the feet, especially between the toes, and associated with maceration and scaling, assess "alteration in skin integrity – tinea pedis."
- If the itching is located in the groin, especially where clothing touches the skin in the groin area, and the skin is reddened and raw, assess "alteration in skin integrity – tinea cruris."
- If the itching is limited to the scalp and associated with dandruff but inflammation is absent except for excoriations, assess "alteration in skin integrity – dandruff."
- If the itching is scattered over the torso and upper arms (may also be more extensive) and associated with small round or leaf-shaped areas of increased or decreased pigmentation but with no inflammation, assess "alteration in skin integrity – tinea versicolor."
- If the patient has been exposed to heat or sun and the exposed areas are covered with tiny (less than 0.5 mm) blisters, with or without peeling, assess "alteration in skin integrity – miliara (heat rash)."
- If the lesions are irregularly shaped and found especially on flexor surfaces or palmar surfaces, and characterized by inflamed skin with peeling, with or without weeping, and the lesions have bee present intermittently for years, assess "alteration in skin integrity – eczema."
- If the itching is associated with blisters on a reddened base, and the blisters are in linear streaks and clumps, assess as "alteration in skin integrity – contact dermatitis, possible poison ivy."
- If the itching is associated with jewelry and the lesion is either blistered or just thickened and hyperpigmented, assess "alteration in skin integrity – nickel allergy"
- If the itching is associated with thickened reddened skin

# Common Skin Problems – Itching

**(this is a three page pathway)**

CCS CORRECT CARE SOLUTIONS



| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

with silvery scales, especially over joint or extensor surfaces, assess "alteration in skin integrity – possible psoriasis."
- If any of the lesions are additionally characterized by pus, pustules, or extensive weeping from an inflamed base, also assess "alteration in skin integrity – (previous assessment) with secondary infection."
- If ectoparasites are suspected, exit this pathway.
- For any itching lesion that does not fit the above, assess "alteration in skin integrity - itching of unknown etiology."

**P: Interventions:**

For "xerosis secondary to personal hygiene"
- Advise patient to reduce frequency and duration of bathing, and especially to use less soap.
- Advise patient that problem will resolve if he stops and additionally stops scratching.
- Advise patient to return if he follows advice and problem persists for more than two weeks.
- If patient has returned, schedule for routine chart review by HCP to determine appropriate follow-up care.

For "alteration in skin integrity – tinea pedis"
- Advise patient to keep feet clean and dry.
- Advise patient that the problem is caused by a fungus that resides underneath the dead outer skin layers, and that the fungus is very difficult if not impossible to eradicate.
- Advise patient that unless secondary infections develop, the problem is considered non-serious Inform patient that antifungal cream is available from the commissary if they want it. Otherwise, general measures are all that will be provided.
- If the toe webs are severely macerated and bleeding or filled with pus, refer patient to HCP for treatment of secondary infection.

For "alteration in skin integrity – tinea cruris"
- Advise patient to keep groin clean and dry.
- If the area is severely macerated, refer to HCP per routine.
- If the area is not severely macerated, advise patient that local hygiene measures will suffice to control problem.
- If patient remains in severe discomfort despite these measures, refer to HCP per routine.

For "alteration in skin integrity – dandruff"
- Advise patient that dandruff is a cosmetic problem and that we do not treat it.
- If scalp inflammation or infections are noted, refer to HCP for further evaluation per routine.

For "alteration in skin integrity – tinea versicolor"
- Advise patient that this is a minor fungal infection that is cosmetic in nature.
- If this is the third such visit or patient complains of severe pruritis, refer to HCP for chart review to determine appropriate follow-up and treatment.
- **If itching is severe and disabling**, refer to HCP for chart review to determine plan of care..

For "alteration in skin integrity" – miliara (heat rash)."
- Advise patient that the problem has developed because of blockage of sweat glands and that no treatment is necessary.

For "alteration in skin integrity – eczema"
- Refer patient for routine visit with HCP per routine.

For "alteration in skin integrity – contact dermatitis, possible poison ivy" or "alteration in skin integrity – possible nickel allergy"
- Advise patient to discontinue exposure to allergen. If linear patterns are identified, consider the likelihood of exposure to poison ivy or oak.
- Have patient wash exposed areas with soap.
- If the lesions are present where jewelry or metal contact the skin, advise the patient that he is allergic to nickel and to avoid contact.
- If itching is severe and involves less than 9 percent of the body (rule of nines-see page 3), provide patient with hydrocortisone 1%, 30 gm for TID application
- If more than 9% of the body is involved, contact HCP for direction.
- If patient is repeatedly being seen for this problem, refer to HCP for evaluation per routine.

For "alteration in skin integrity – possible psoriasis"
- Refer to HCP for evaluation per routine.

For "alteration in skin integrity – (previous assessment) with secondary infection"
- Refer to HCP for evaluation per routine.

For "alteration in skin integrity - itching of unknown etiology"
- Refer to HCP for evaluation per routine.

Comments: _____

# Common Skin Problems – Itching

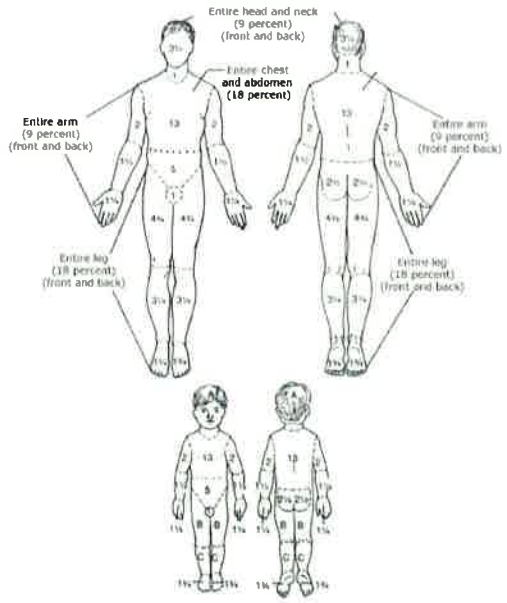
**(this is a three page pathway)**



| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Nurse's signature and date:

Reviewer's signature and date:




**Percentage based on age**

| | Birth- 1 yr | 1-4 yr | 5-9 yr | 10-14 yr | 15 yr | Adult |
|---|---|---|---|---|---|---|
| A. Head | 19 | 17 | 13 | 11 | 9 | 7 |
| B. Thigh | 5.5 | 6.5 | 8 | 8.5 | 9 | 9.5 |
| C. Leg | 5 | 5 | 5.5 | 6 | 6.5 | 7 |

# Common Skin Problems
# Skin Infections

| Patient Name | Inmate Number | Booking Number | Date of Birth | Today's Date |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.
Date: _____ Time: _____

**S: Subjective:**

Patient complains of boil, abscess, infection near fingernail, abnormal nail(s), shave bumps, diffuse red and weeping skin, etc. Inquire:
What areas are involved? _____
_____
_____
_____
How long has the problem been going on? _____
_____
_____
How did it start? How has it changed? What have you done for it? _
_____
_____
_____
Has this happened before?_____
_____
_____
_____

**O: Examination:**

T: _____ P:_____
Inspect and describe the lesion(s). Note number and distribution, erythema, swelling, pus or other drainage, heat, etc_____
_____
_____
_____
_____
_____
_____
_____

**A: Assessment:**

- If there is a small subcutaneous mass with associated heat, erythema, and tenderness, assess "alteration in skin integrity – abscess" (if there are multiple abscesses, indicate that).
- If there is diffuse erythema and warmth, with associated weeping, assess "alteration in skin integrity – possible cellulitis."
- If there are pustules distributed in a hair follicle pattern, assess "alteration in skin integrity – possible folliculitis." If the distribution is on the face where the patient has shaved, assess "alteration in skin integrity – pseudofolliculitis barbae (shave bumps)."
- If there is heat, swelling, erythema, and tenderness around a nail, assess "alteration in skin integrity – paronychia."
- If there are thickened, irregular, flaking, discolored nails, assess "alteration in skin integrity – onychomycosis."

Assessment _____

**P: Interventions:**

For "alteration in skin integrity – abscess"
- Advise patient to apply moist warm compress (washcloth in hot water will suffice) to isolated abscess, for 20 minutes three or four times daily.
- Advise patient that abscess will likely "point" and drain within three days.
- If abscess is surrounded by more than a thin rim of erythema or if patient has temperature above 100, contact HCP for direction.
- If abscess enlarges or becomes multiple, contact HCP for direction.

For "alteration in skin integrity – possible cellulitis"
- Contact HCP for direction.

For "alteration in skin integrity – possible folliculitis"
- Contact HCP for direction.

For "alteration in skin integrity – pseudofolliculitis barbae (shave bumps)"
- Advise patient that the problem is caused by curled hairs growing into the skin.
- If the area is infected (pustules with erythema), refer to HCP for treatment.
- If the area is not infected, advise the patient to avoid the problem by not shaving (some facilities will permit use of clippers to leave a short hair above the skin-line, and others will permit beards. Do what your facility permits.)

For "alteration in skin integrity – paronychia"
- Advise patient to soak finger in warm water (cup of water just cool enough to use is perfect) for 20 minutes three or four times a day.
- Advise patient that the infection will likely "point" and drain."
- If the infection persists for more than 48 more hours after treatment is initiated, if it begins to spread towards the hand (or foot), or if the patient has a temperature of 100 or more, contact HCP for direction.

For "alteration in skin integrity – onychomycosis"
- Advise patient that the nail is infected by a fungus that lives in dead skin and nails.
- Advise patient that the problem is not serious and is primarily cosmetic, and that it will not be treated in the correctional setting.

Comments:
_____
Nurse's signature and date:
_____
Reviewer's signature and date:
_____

# Constipation

| Patient Name | Inmate Number | Booking Number | Date of Birth | Today's Date |
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Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**
Patient complains of constipation. Inquire:
Describe your normal bowel habits and how they have changed._____

Have you had trouble controlling your bowel movements?

Describe any abdominal pain, cramps, bleeding, nausea, or bloating? _____

Has your weight changed? Was it because you wanted to lose/gain? _____

What medications do you take? Any recent changes? _____

**O: Examination:**
T: _____ P:_____ R:_____B/P:_____ Wt:_____
Inspect and palpate the abdomen, being alert to rebound tenderness. _____

If obstipation seems present, perform a digital rectal exam to identify fecal impaction. _____

**A: Assessment:**
- If vital signs are normal and symptoms are limited to general discomfort and bloating with minimal local cramping assess "alteration in GI function – constipation."
- If vital signs are abnormal, rebound tenderness is present, nausea and vomiting are noted, a rectal mass is noted, bleeding is described, or a recent medication change is noted, assess "alteration in GI function of undetermined cause."
- If a rectal mass was identified upon digital examination but the patient is otherwise normal, assess "alteration in GI function – rectal mass."

**P: Interventions:**
**If significant pain is present, this pathway is not applicable**

For "alteration in GI function – constipation"
- Advise patient regarding exercise, diet, and fluid intake. No medication is necessary.
- If patient has returned a third time complaining of constipation, refer to HCP for routine chart review for appropriate treatment and follow-up.

For "alteration in GI function of undetermined cause"
- Refer patient to HCP for routine evaluation.
- If symptoms appear to warrant more urgency (for example, patient describes disabling pain) exercise clinical judgment regarding the timeframe for evaluation.

For "alteration in GI function – rectal mass"
- Refer to HCP for routine evaluation. Depending upon the patient's mental status, this referral may be handled more urgently.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

# Dandruff

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
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Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient complains of dandruff. Inquire:
How long has the problem existed? _____

Has it occurred at other times? _____

What other problems are present? _____

Has there been any bleeding? _____

Has there been any pain? _____

**O: Examination:**

Inspect the scalp. Search specifically for infections, bleeding, or erythematous lesions. Look for signs of lice. _____

Palpate the scalp for nodules or thickened patches. _____

**A: Assessment:**

If no discrete lesions are present on the scalp, assess "dandruff."
If discrete lesions are identified, assess "alteration in skin integrity - scalp."
If nits or lice are identified, assess "lice."
Assessment _____

**P: Interventions:**

For "dandruff"
- Advise the patient that this is a cosmetic problem and that no treatment will be provided.
- Advise patient that excessive washing can result in additional flakiness.

For "alteration in skin integrity – scalp"
- Contact the HCP for direction.

For "lice"
- Exit this clinical pathway and use the appropriate one (ectoparasites).

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

# Dental Pain

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
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Check, circle, and complete all appropriate blanks.

If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient complains of mouth pain. Inquire:
When did the pain start? _____

Is this the first time you have experienced this pain? _____

Did the pain begin abruptly or come on slowly. _____

Is the pain intermittent or constant. _____

Is the pain associated with any specific foods, food temperatures, or any activities. _____

Rate the pain on a scale of 1 to 10, with 10 the worst._____
Is there any associated bleeding._____

**O: Examination:**

T: _____ WT: _____
Inspect the gums and teeth, noting especially any redness, any pus or other discharge, and any swelling. _____

Palpate under the jaw for swollen lymph nodes or local tenderness. _____

Palpate along the outer border of the mandible for severe tenderness (suggestive of parotid gland duct blockage) _____

**A: Assessment:**

- If the pain appears to be related to teeth and there is no inflammation or other complicating factor, assess as "tooth pain."
- If the pain appears to be related to teeth and there is inflammation, obvious swelling, or pus-like drainage, assess as "tooth pain with infection."
- If there is a swollen salivary gland and acute localized tenderness suggestive of salivary duct blockage, assess as "alteration in comfort – possible salivary gland duct blockage."

**P: Interventions:**

For "tooth pain"
- Schedule to see the dentist at the next clinic.
- Advise patient to rinse with warm salt water four times daily until dental appointment.
- Offer acetaminophen 975 mg PO BID (three 325 mg tablets) twice daily for 7 days.
- Offer patient choice of warm compress or ice pack for comfort.

For "tooth pain with infection"
- Contact dentist for direction.

For "alteration in comfort – possible salivary gland duct blockage"
- Contact HCP for direction

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

# Diarrhea

| Patient Name | Inmate Number | Booking Number | Date of Birth | Today's Date |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.

If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient complains of diarrhea. Inquire:
When did it begin, how often does it occur? Any history of Crohn's disease or ulcerative colitis? _____

What is it like – consistence, content, color? Is it bloody? Watery? Full of Mucus? How large are the movements? ____

Is there cramping or other pain? Describe: _____

Have there been any recent changes in food habits, or any new medications? _____

Are others in the housing unit or on the same assignment having the same problem? _____

**O: Examination:**

T: _____ P:_____ R:_____B/P:_____ WT:_____
If the diarrhea is described as being of a large quantity or long-lasting, check the skin for the quality of its turgor and include blood pressure and pulse readings both upright and lying flat. _

Inspect and palpate the abdomen, being alert for signs of rebound tenderness. _____

Listen to the abdomen and bowel sounds. _____

**A: Assessment:**

- If vital signs are normal, there is no suggestion of dehydration, and there are no complicating factors such as vomiting or bleeding, assess "alteration in GI function – diarrhea, nonspecific."
- If the diarrhea appears caused by a change in food habits or a specific food, assess "alteration in GI function – diarrhea, food-related."
- If there is a complicating factor such as dehydration, bleeding, fever over 101 F, disabling pain assess "alteration in GI function – diarrhea, complicated."

Assessment: _____

**P: Interventions:**

For "alteration in GI function – diarrhea, nonspecific"
- advise the patient to drink plenty of fluids, offer a clear liquid diet for 48 hours
- Advise the patient to return for reevaluation if not better in two days.
- If diarrheal stools are occurring more often than once every 2 hours, offer loperamide 4 mg po once.
- If stool frequency remains unaffected, contact the HCP for direction.

For "alteration in GI function – diarrhea, food-related"
- Advise the patient to drink plenty of fluids.
- Offer a clear liquid diet for 48 hours.
- Advise the patient to avoid the suspect food.
- Advise the patient to request reevaluation by the nurse if not better within two days.

For "alteration in GI function – diarrhea, complicated"
- Contact the HCP for direction.

Comments: _____

Nurse's signature and date:

_____

Reviewer's signature and date:

_____

# Dyspepsia and Acid Complaints

| Patient Name | Inmate Number | Booking Number | Date of Birth | Today's Date |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient complains of heartburn.
Inquire regarding the type and severity of the pain, the frequency with which it occurs, and its relationship to meals. _____

Inquire what makes the pain worse and what makes it better.

Inquire if the patient has ever been treated for ulcer disease or acid reflux disease (GERD). Any hospitalizations for GI bleeding? _____

Inquire if the patient has been treated with antimicrobials for H pylori (or knows of such treatment). _____

Inquire if the patient has ever been treated for heart disease (and if so, what?). _____

Inquire regarding any relationship between exercise and the pain.

Inquire regarding the frequency of, quantity of, and last alcohol use.

Inquire regarding other medication usage, especially NSAIDs (aspirin, ibuprofen, naprosyn, etc). _____

**O: Examination:**
P:_____ R:_____ B/P:_____ Wt:_____
Listen to the abdomen, identifying bowel sounds. _____

Palpate the abdomen and search for rebound tenderness. _____

**A: Assessment:**
If the pain is consistent with dyspepsia and inconsistent with cardiac pain, assess as "alteration in comfort – dyspepsia."
If the pain is also consistent with cardiac pain, assess as "alteration in comfort - dyspepsia versus cardiac disease."
If rebound tenderness is present or vital signs are abnormal (other than pulse mildly elevated to no more than 110 bpm), assess as "alteration in comfort – unknown etiology."
Assessment _____

**P: Interventions:**
For "alteration in comfort – dyspepsia"

- Offer liquid antacid 30 cc by mouth (if patient is in renal failure, contact HCP for direction)
- If pain is not relieved, contact HCP for direction.
- If pain is relieved, and this is the third visit for the problem, schedule patient for a chart review by HCP to determine appropriate treatment and follow-up. Provide liquid antacid 30 cc by mouth QID until chart reviewed and further orders given.
- Educate patient regarding non-specific dyspepsia:
  - Avoid caffeine.
  - Avoid food before going to bed.
  - Avoid high fat snacks.
  - Avoid nicotine and alcohol.

For "alteration in comfort - dyspepsia versus cardiac disease"

- Offer liquid antacid 30 cc by mouth (if patient is in renal failure, contact HCP for direction)
- Contact HCP for direction.

For "alteration in comfort – unknown etiology"

- Contact HCP for direction.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

# Ectoparasites
# FEMALE patients

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient presents with itching or complaining of "bugs." _____

When did the problem develop? _____

When and where does it itch? _____

Is it worse at night? _____
Have you seen any insects on your skin? _____

Ask if anyone in the housing area has been itching or recently treated for lice or scabies. _____

**O: Examination:**

Inspect the skin. Look both at affected and unaffected areas.

Document excoriations and/or secondary infections. _____

Inspect the hair in affected areas searching for nits (scalp, pubic hair). _____

Examine clothing seams for lice. _____

**A: Assessment:**

If lice are identified, assess as "alteration in skin integrity – lice."
If scabies is identified, assess as "alteration in skin integrity – scabies."
If no ectoparasites are identified, assess as "alteration in skin integrity – itching (or pruritis) of unknown significance."
Assessment _____

**P: Interventions:**

For "alteration in skin integrity – lice"

- If patient is pregnant, contact HCP for direction. Otherwise, follow the following steps.
- Place patient in medical isolation for duration of treatment. Provide over-the-counter pyrethrin-based or permethin-based insecticide for use upon receipt and 5 days later.
- On treatment day 3, saturate long hair with mayonnaise and cover with shower cap; wash off after 24 hours. **(Note: patients with very short hair may be managed as described in Ectoparasites: Male Patients)**
- If available, provide nit comb to reduce nit load.
- (For facilities that separate lice patients from general population, nursing staff will evaluate after last stage of treatment to determine if patient may be returned to general population.)
- Instruct patient to launder clothing and bedding. Items that cannot be laundered must be "taken out of service" for two weeks or wiped down with an insecticide solution.

For "alteration in skin integrity – scabies"

- Contact HCP on-call for advice.

For "alteration in skin integrity – itching of unknown significance"

- Schedule patient to HCP per routine.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date:

# Ectoparasites-MALE patients

CCS CORRECT CARE SOLUTIONS

| *Patient Name* | *Inmate Number* | *Booking Number* | *Date of Birth* | *Today's Date* |
|---|---|---|---|---|
| | | | | |

Check, circle, and complete all appropriate blanks.
If it has been noted that patient has been putting in numerous sick calls for similar complaints, refer patient for chart review with HCP to determine appropriate plan of care and follow-up.

Date: _____ Time: _____

**S: Subjective:**

Patient presents with itching or complaining of "bugs." _____

When did the problem develop? _____

When and where does it itch? _____

Is it worse at night? _____
Have you seen any insects on your skin? _____

Ask if anyone in the housing area has been itching or recently treated for lice or scabies. _____

**O: Examination:**

Inspect the skin. Look both at affected and unaffected areas.

Document excoriations and/or secondary infections. _____

Inspect the hair in affected areas searching for nits (scalp, pubic hair). _____

Examine clothing seams for lice. _____

**A: Assessment:**

If lice are identified, assess as "alteration in skin integrity – lice."
If scabies is identified, assess as "alteration in skin integrity – scabies."
If no ectoparasites are identified, assess as "alteration in skin integrity – itching (or pruritis) of unknown significance."
Assessment _____

**P: Interventions:**

For "alteration in skin integrity – lice"

- Provide over-the-counter pyrethrin-based or permethrin-based insecticide for use upon receipt and one week later.
- If available, provide nit comb to reduce nit load.
- Instruct patient to launder clothing and bedding. Items that cannot be laundered must be "taken out of service" for two weeks or wiped down with an insecticide solution.
- **Note: For patients with long hair, manage as under "Ectoparasites: Female Patients.**

For "alteration in skin integrity – scabies"

- Contact HCP for advice.

For "alteration in skin integrity – itching of unknown significance"

- Schedule patient to HCP per routine.

Comments: _____

Nurse's signature and date:

Reviewer's signature and date: